1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04113

CERTIFICATE OF DEATH

4124

Reg. Dist. No. 195

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Guilford Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
d. STREET ADDRESS: Guilford Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Nancy — Middle: Elizabeth — Last: Duvall

4. DATE OF DEATH: Month, Day, Year: April 20, 1956

5. SEX: Fem

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: August 8, 1870

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elijah S. Riley

14. MOTHER'S MAIDEN NAME: Elizabeth Jarmas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Nettie Brown 818 W.36th St., Balt., Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

	Cause	Interval between onset and death
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Terminal Bronchopneumonia	1 wk
DUE TO (b)	Arteriosclerotic C-V-Dis.	5 yrs
DUE TO (c)	Generalized Arteriosclerosis	10 yrs

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obliterative Arteritis legs. Gangrene

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/18 1939 to 4/20 1956 that I last saw the deceased alive on 4/19 1956, and that death occurred at 5 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: J M Warren M.D. — ADDRESS (Street, city or town, state): 305 Mo. Geo. Laurel — DATE SIGNED: 4/20/56

PHYSICIAN'S NAME (Type): J. M. Warren

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 23,1956

22c. NAME OF CEMETERY OR CREMATORY: Savage Cemetery

22d. LOCATION (City, town, or county) (State): Savage, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: [signature] Donaldson Laurel, Md

24a. REC'D BY REGISTRAR — DATE 4/22/56

24b. REGISTRAR'S SIGNATURE: Mark Shipley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

! 4125 **CERTIFICATE OF DEATH**

04115

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 2days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Shaffer Convalescent Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 225 9th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle M. — Last Jones

4. DATE OF DEATH: Month April — Day 13 — Year 1956

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 14, 1913
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Frostburg, Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward G. Arnold
14. MOTHER'S MAIDEN NAME: Mary Keirs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wm. C. Jones — Address: 225 9th St., Laurel, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Edema, Acute	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Congestive Heart Failure	10 yrs
DUE TO (c)	Nephritis, Chronic	10 yrs

592X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Asthma, Recurrent

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): None
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY: Month, Day, Year, Hour a.m. p.m.: None 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐: None
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None
20f. (City or town) (County) (State): None

21. I certify that I attended the deceased from 1/17 19 56 to 4/13 19 56 that I last saw the deceased alive on 4/12 19 56, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Erickson M.D. — ADDRESS (Street, city or town, state): Laurel, Maryland — DATE SIGNED: 4/14/56

PHYSICIAN'S NAME (Type): R. L. Erickson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 17, 1956
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park
22d. LOCATION (City, town, or county) (State): Frostburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible] Laurel Md
24a. REC'D BY REGISTRAR DATE: APR 16 1956
24b. REGISTRAR'S SIGNATURE: John Laughran

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04116

4126 CERTIFICATE OF DEATH

Item 7, FilmC196 5-2-56et

Reg. Dist. No. 191

1. PLACE OF DEATH
COUNTY HOWARD — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY
LENGTH OF STAY (in this place) 1 WK.
HOSPITAL OR INSTITUTION OR STREET ADDRESS SHAFFERS NURSING HOME MONTGOMERY ROAD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3 V 0 1 - 4
STREET ADDRESS (If rural give location) 804 EVESHAM AVE.

3. NAME OF DECEASED (Type or Print) (First) HENRY (Middle) G. (Last) MAYNADIER

4. DATE OF DEATH (Month) April (Day) 25 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	Single	AUG. 15, 1871	84 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BANKER	FINANCE	HARFORD Co. MD.	U.S.

13. FATHER'S NAME GEORGE YELLOTT

14. MOTHER'S MAIDEN NAME LAURA THOA MOORES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS COLIN F. MACKENZIE 814 EVESHAM AVE.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X IMMEDIATE CAUSE (A) CEREBRAL THROMBOSIS + SOFTENING — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) CEREBRAL ARTERIOSCLEROSIS — 10 yrs
DUE TO (C) SENILITY — 10 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION None — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 19 56, to April 25 19 56, that I last saw the deceased alive on April 22 19 56, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE A. S. Ohalpant M.D. — ADDRESS (Street, city, town, state) 6210 York Rd Baltimore 12 Md. — DATE SIGNED Apr 26 56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	4/28/56	CHRIST CHURCH CEM.	ROCK SPRING, FOREST HILL	MD.

24. REC'D BY REGISTRAR DATE APR 30 1956 — REGISTRAR'S SIGNATURE John B Longhenry

25. FUNERAL DIRECTOR'S SIGNATURE W. Wm Jenkins & Bros Co. — ADDRESS 4905 York Rd

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04117

4127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Howard, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 35 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: Route #97
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nina Middle: Davis Last: Meadows
4. DATE OF DEATH: Month: April Day: 15 Year: 1956

5. SEX: Female
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 2, 1895
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fletcher Meadows
14. MOTHER'S MAIDEN NAME: Josephine Rucker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT (Address): Miss Cora E. Meadows - Ellicott City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac Arrest, pneumonia,	Oct.
DUE TO (b)	Carcinoma of breast with generalized	1954
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Metastases -	April '56

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 19 1954 to April 1956 that I last saw the deceased alive on 15 April 1956, and that death occurred at 10:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E. Hall M.D. ADDRESS (Street, city or town, state): Sykesville, Md. DATE SIGNED: 4-16-56

PHYSICIAN'S NAME (Type): HOWARD E. HALL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/20/56
22c. NAME OF CEMETERY OR ~~CREMATORY~~: River View
22d. LOCATION (City, town, or county) (State): Martins Henry + Ohio

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Luther H. Haight - Clarksville Md
24a. REC'D BY REGISTRAR DATE: APR 18 1956
24b. REGISTRAR'S SIGNATURE: A. H. Hobbs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04118

4128

CERTIFICATE OF DEATH

Reg. Dist. No. 195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mission Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
d. STREET ADDRESS: Mission Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: A. — Last: Ohler

4. DATE OF DEATH: Month: April — Day: 15 — Year: 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 23 1866

9. AGE (If years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: publishing Co.

11. BIRTHPLACE (State or foreign country): Waterloo Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam N. Ohler

14. MOTHER'S MAIDEN NAME: Sallie Maria Baldwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mr. Jean M. Urban Jessup Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 hr.
420.1
DUE TO
(b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-29, 1956, to 4-11, 1956, that I last saw the deceased alive on 4-11, 1956, and that death occurred at 9:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank L. Weaver Jr. M.D. — ADDRESS (Street, city or town, state): 320 Montgomery, Laurel, Md — DATE SIGNED

PHYSICIAN'S NAME (Type): FRANK L WEAVER JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 4/17/56

22c. NAME OF CEMETERY OR CREMATORY: Patuxent Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Davidson — ADDRESS: Laurel Md

24a. REC'D BY REGISTRAR DATE: 4/17/56

24b. REGISTRAR'S SIGNATURE: Frank Shipley

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4129

04119

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 3 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Highland Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d STREET ADDRESS: 325 Laurel Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dora Middle C Last OWENS

4. DATE OF DEATH: Month April Day 13 Year 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 14 1870

9. AGE (In years last birthday) 85 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Savage Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Walter Owens

14. MOTHER'S MAIDEN NAME: Laura Virginia Haslup

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mrs. Wm. G. Eccard, 325 Laurel Ave. Laurel, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO (b) Hypertensive CVD — 20yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 1956 to April 13, 1956 that I last saw the deceased alive on April 1, 1956, and that death occurred at 5 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Max J Miller M.D. ADDRESS (Street, city or town, state): 5226 Balt. Nat. Pike DATE SIGNED: 4/14/56

PHYSICIAN'S NAME (Type): MAX J MILLER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 15, 1956

22c. NAME OF CEMETERY OR CREMATORY: Savage Cemetery

22d. LOCATION (City, town, or county) (State): Savage, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Dr. Wm. Hamilton ADDRESS: Laurel Md

24a. REC'D BY REGISTRAR DATE: APR 17 1956

24b. REGISTRAR'S SIGNATURE: John Langhenry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: [redacted] after this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04120

4130

CERTIFICATE OF DEATH

Reg. Dist. No. 191

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 8 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Highland Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 120 W. Lanvale St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Small; Last: Reiley

4. DATE OF DEATH: Month: April; Day: 17; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 24, 1866

9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: school teacher

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Rev. James McKendree Reiley

14. MOTHER'S MAIDEN NAME: Margaret Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Margaret Stevenson — Address: 2733 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vasc. Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 19 55, to April, 19 56, that I last saw the deceased alive on 4/14, 19 56, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Max J Miller MD — M.D. — ADDRESS (Street, city or town, state): 5226 Balt Nat Pike — DATE SIGNED: 4/17/56

PHYSICIAN'S NAME (Type): MAX J MILLER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 20, 1956

22c. NAME OF CEMETERY OR CREMATORY: Green Mount

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John O. Mitchell & Sons Inc. 1900 Eutaw Place

24a. REC'D BY REGISTRAR — DATE

24b. REGISTRAR'S SIGNATURE: J. E. Loughran

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04122

4131

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Savage
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Guilford Road

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Savage
d STREET ADDRESS: Guilford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MELVIN Middle Jackson Last SCOTT

4. DATE OF DEATH: Month April Day 27 Year 1956

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 18, 1866
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): textile worker
10b. KIND OF BUSINESS OR INDUSTRY: cotton mill
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Scott
14. MOTHER'S MAIDEN NAME: ——— Norman

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Thomas R. Scott, Savage, Maryland — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Inst.
DUE TO
(b): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 4/27, 1956, to 4/27, 1956, that I last saw the deceased alive on 4/27, 1956, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. M. Warren M.D. — ADDRESS (Street, city or town, state): Laurel — DATE SIGNED: 4/27/56

PHYSICIAN'S NAME (Type): J. M. Warren

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 30, 1956
22c. NAME OF CEMETERY OR CREMATORY: Savage Cemetery
22d. LOCATION (City, town, or county) (State): Savage, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert Howard — ADDRESS: Laurel, Md.
24a. REC'D BY REGISTRAR DATE: 4/30/56
24b. REGISTRAR'S SIGNATURE: Frank Shipley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04123

4132

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 13 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Taylor Manor Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
d. STREET ADDRESS: 123 South Oak Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HUGO Middle Lost SPELSBERG

4. DATE OF DEATH: Month APRIL Day 20 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 15, 1894

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR Months / IF UNDER 24 HRS. Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10b. KIND OF BUSINESS OR INDUSTRY: Food Industry

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert Spelsberg

14. MOTHER'S MAIDEN NAME: Matilda Czesky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Caroline G. Spelsberg, 123 Oak St. Clarksb erg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
305x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pre-Senile Brain Disease with Psychotic Reaction — 8 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9 JAN 56, 19____, to 20 APR 56 19____, that I last saw the deceased alive on 20 APR 56, 19____, and that death occurred at 9:25 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur V. Milholland M.D. ADDRESS (Street, city or town, state): Taylor Manor Hosp. Ellicott City Md. DATE SIGNED: 20 APR 56

PHYSICIAN'S NAME (Type): Arthur V. Milholland, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: April 21, 1956

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or county) (State): Clarksburg, W. Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William J. Tucker & Son Baltimore, Md.

24a. REC'D BY REGISTRAR: April 21, 1956

24b. REGISTRAR'S SIGNATURE: R. W. J. E. Loughran

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04124

Reg. Dist. No. 1 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sykesville rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1½ mile S. of Sykesville Rt. 32

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HOWARD Last UNGLESBEE

4. DATE OF DEATH: Month April Day 24 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-10-1932

9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Koontz Dairy

11. BIRTHPLACE (State or foreign country): Ellicott City, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William K. Unglesbee

14. MOTHER'S MAIDEN NAME: Ruth E. Bloom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: W. K. Unglesbee, Sykesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Compound Comminuted Fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple Fractures

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto failed to make right curve and struck utility pole

20c. TIME OF INJURY Hour 7.30 P. m. Month, Day, Year 4-24-56 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 32

20f. (City or town): Sykesville (County): Howard (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: George E. Burgtorf M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: April 24, 1956

EXAMINER'S NAME (Type): George E. Burgtorf

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-27-56

22c. NAME OF CEMETERY OR CREMATORY: National Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. C. Higinbothom, Ellicott City, Md.

24a. REC'D BY REGISTRAR DATE 4-27-56

24b. REGISTRAR'S SIGNATURE: Alice M. Hebb

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4134 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04125 Reg. Dist. No. 195

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Howard — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Savage — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30 3Vol-4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt.1	d. STREET ADDRESS: 929 S.Sharp St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mc KINLEY		WALLACE	April	13	19 56

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Colored		1905	51 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel Wallace	Ella Gross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes ✓	?		Florence Wallace, 929 S.Sharp St. Baltimore 30

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour (o m. / p. m) Month, Day, Year 19	20d. INJURY OCCURRED While at work ☒ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE George E. Burgtorf M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED 4-13-56

EXAMINER'S NAME (Type) George E. Burgtorf

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4-17-56	Browns	Calvert County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Marshall P. Hayes, 638 N. Gilmore St, Baltimore, Md.	4/16/56	Frank Shipley

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04126 / 193

4135

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Friendship
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Friendship
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First C. Middle ORMAN Last WILCOX

4. DATE OF DEATH: Month APRIL Day 28 Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: SEPT 1883
9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Blacksmith
11. BIRTHPLACE (State or Foreign country): HOWARD Co. Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: CHARLES WILCOX
14. MOTHER'S MAIDEN NAME: REESE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MARGARET MERSON
Address: 3419 KLEINWICK Rd BALTO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shot Gun Wound of Head
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot Gun wound of Head
20c. TIME OF INJURY: Hour o. m. p. m. ? Month, Day, Year 19
20d. INJURY OCCURRED: While at work [X] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) West Friendship (County) Howard (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined cause [X].

ACTUAL SIGNATURE: George E Burgtorf M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 4-28-56
EXAMINER'S NAME (Type): George E. Burgtorf

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 2, 1956
22c. NAME OF CEMETERY OR CREMATORY: MT VIEW
22d. LOCATION (City, town, or county) (State): ALPHA, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. C. HIGINBOTHAM
ADDRESS: ELLICOTT CITY Md
24a. REC'D BY REGISTRAR DATE: May 1, 56
24b. REGISTRAR'S SIGNATURE: Vivian M. Keith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04127

4136 CERTIFICATE OF DEATH

Reg. Dist. No. 190

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH

COUNTY: Howard — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harwood Park

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 6910 Highland Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md. COUNTY: Howard

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harwood Park

STREET ADDRESS (If rural give location): 6910 Highland Ave.

3. NAME OF DECEASED (Type or Print): (First) LEWIS (Middle) MILTON (Last) YOUNG

4. DATE OF DEATH: (Month) April (Day) 8, (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Jan. 15, 1892	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	construction	Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clark Young	- Fogel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	215-05-0634	Mrs. Anna Young-6910 Highland Ave.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Myocardial Infarct (2)

ANTECEDENT CAUSE(S) DUE TO (B) Coronary Thrombosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2, 6 ..., 1954, to 4/8 ..., 1956, that I last saw the deceased alive on 4/5 ..., 1956, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

SIGNATURE John E. Thurn M.D. ADDRESS (Street, city, town, state) Frederick, Md. DATE SIGNED 4-13-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/11/56	Meadowridge	Elkridge, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
APR 11 1956	E. Bird Thurn	Wm. J. Tietze & Sons-Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4137 **CERTIFICATE OF DEATH** Reg. Dist. No. 04128

1. PLACE OF DEATH:
COUNTY Howard MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge
LENGTH OF STAY (in this place) 2½ mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6433 old washington Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE ~~Md~~ Va COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Norfolk
STREET ADDRESS (If rural give location) 701 D St. 83X-5

3. NAME OF DECEASED: (First) George (Middle) Robert (Last) Zimmer
4. DATE OF DEATH: (Month) Apr (Day) 16 (Year) 1956
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed
8. DATE OF BIRTH: Sept 9-1879
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpt (Retired)
10B. KIND OF BUSINESS OR INDUSTRY: F.D. Royster Co
11. BIRTHPLACE (State or foreign country): Baltimore City
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 231-10-0305
17. INFORMANT & ADDRESS: Mr Auston Zimmer 6433 old washington Rd

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

33 X

IMMEDIATE CAUSE (A) Apoplexy — 4 da

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO General Arteriosclerosis — 12 yrs

(C) Arterial Hypertension

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Repeated strokes — 5 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1956, to Apr 16, 1956, that I last saw the deceased alive on Apr 15, 1956, and that death occurred at 8:30 A M, from the causes and on the date stated above.
SIGNATURE W. B. Brumbaugh M. D. ADDRESS 1609 main St Elkridge 27 md. DATE SIGNED 4/16/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal
DATE THEREOF 4-16-56
NAME OF CEMETERY OR CREMATORY Indian Rest Cemetery
LOCATION (City, town, or county) (State) Norfolk, Virginia

DATE REC'D BY LOCAL REGISTRAR April 16, 1956
REGISTRAR'S SIGNATURE H. W. Hedrick
24. FUNERAL DIRECTOR ADDRESS Taylor Funeral Home, Catonsville, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04129

4138

CERTIFICATE OF DEATH

Reg. Dist. No. 191

Howard County

1. PLACE OF DEATH: COUNTY ELLICOTT CITY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTO. MD — LENGTH OF STAY (in this place) 2 WEEKS
HOSPITAL OR INSTITUTION OR STREET ADDRESS HIGHLAND MANOR. N. HOME

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE BALTIMORE — COUNTY MD.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) CHURCH RD & 6700 HUDSON ST.

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) (Last) ZUCHOWSKI
4. DATE OF DEATH: (Month) 4 (Day) 18 (Year) 1956

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: 1890
9. AGE last birthday: 66 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): !
10b. KIND OF BUSINESS OR INDUSTRY: !
11. BIRTHPLACE (State or foreign country): BALTIMOR. MD.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: JOSEPH ZUCHOWSKI
14. MOTHER'S MAIDEN NAME: MARY PODLEWSKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: ?
17. INFORMANT AND ADDRESS: MARY GOOD WILL 1104 STEELTON AVE ZONE 24

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Pulm. Edema — 1 hour

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) due to Arteriosel. Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia — 3 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 14, 1956, to April 18, 1956, that I last saw the deceased alive on 4/14, 1956, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Chas J Reilly MD (Degree or title) ADDRESS 5226 Baltimore Ave DATE SIGNED 4/19/56

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 4-21-1956
NAME OF CEMETERY OR CREMATORY: St Stanislaus
LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG. APR 19 1956
REGISTRAR'S SIGNATURE J. E. Loughenbaugh
24. FUNERAL DIRECTOR: Walter Dabrowski — ADDRESS 1001 A. Dundalk Ave.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15